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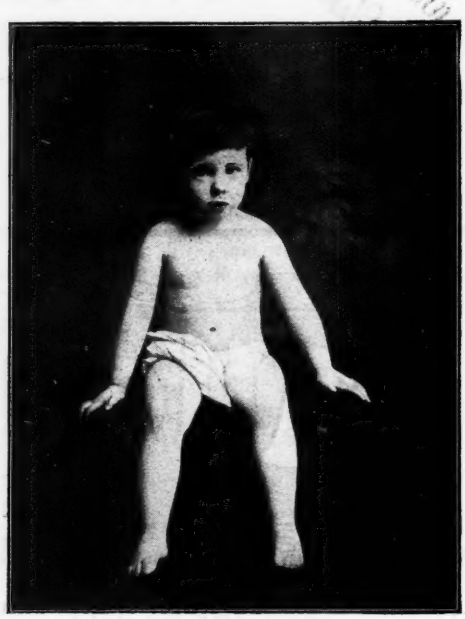

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VIROL

THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—3RD YEAR. SYDNEY: JUNE 3, 1916. No. 23.

CYSTIC OVARIES.[1]

By **William Ritchie, M.B., M.S. (Edin.),**
Armidale, New South Wales.

Every gynæcologist will agree that a large proportion of ovaries he inspects in his abdominal work are affected with small, follicular, cystic degeneration, which usually gives rise to no clinical symptoms. This is found to be the case so often in operating on abnormalities of organs other than the ovaries that there is sometimes a doubt expressed as to whether a surgeon is warranted in treating them in a surgical manner. Roberts, in his book on "Gynæcological Pathology," states that it is doubtful if the small cystic ovary ever causes any clinical symptoms, a statement which, I fancy, would be challenged by the majority of gynæcologists. When pain accompanies such a condition, one of two operations is usually adopted: Kelly's operation of splitting the ovary and evacuating the cysts, or the removal of the organ. During the years I acted as Assistant Surgeon at the Royal Samaritan Hospital, in Glasgow, we began by treating these cases conservatively by Kelly's method, or by the removal of the ovary on the side, which was the seat of most pain, and incision of the other ovary, with evacuation of the cysts. We had so often to operate a second time and to remove the ovary which had been incised on the previous occasion, that we were inclined in all cases of severe ovarian pain, the result of this condition, to remove both ovaries at once and not to attempt incision and evacuation.

This state of affairs is most unsatisfactory. It leaves unexplained why pain resulted in some cases and not in others, why some women had to sacrifice their ovaries on account of pain, menstrual and intramenstrual, while others were free from pain and spent many comfortable and reproductive years, the happy possessors of cystic ovaries.

As in most similar circumstances, the solution is to be found in the pathology of the condition. In no pathological text-book dealing with small cystic ovaries have I seen any clue which solves the mystery. I have failed to find any reasons given why some small cystic ovaries are different from others in any respect, as they obviously must be if some are clinically so harmful that their removal is necessary, while others are not. This fact, I take it, will not be disputed. The writers all dilate on the pathology of the ovarian substance containing the cysts, but beyond that they do not go. It is beyond that that the solution of the riddle lies. If my theory is right, and I hope to substantiate it with proof, it is not the condition of the ovarian substance that we need concern ourselves with, but the pathological condition of the *tunica albuginea*. I have seen no reference to the *tunica albuginea* in any book dealing with cystic ovaries; yet the recognition of the fact that the difference in these ovaries lies in the difference of their tunica clears up the difficulty in explaining the different clinical features of cystic ovaries. It, I submit, can do more than that; it will save women, whose cystic ovaries cause them marked pain, from being unsexed before the natural menopause.

The cystic ovaries which cause pain are those which have a thickened *tunica albuginea*, and, conversley, those which are painless have not. Having come to this conclusion, there is not much difficulty in explaining the pain, which, of course, is due to increased pressure on the resisting tunica. It is absent in those cases where the tunica does not offer resistance. The operation I have devised depends on this fact, and I hope to show you its results have been satisfactory. It is an operation of partial denudation, and is carried out as follows:—

After the abdomen has been opened in the usual way, the ovary is exposed and a strip of the tunica, about ¼ in. or ⅓ in. broad, is dissected off in the long axis of the organ for its whole length. Hæmorrhage is dealt with by mattress sutures, which do not approximate the edges of that portion of the tunica on each side of the denuded surface. The area which is denuded is chosen on the side of the ovary nearest the broad ligament, and the operation is completed by stitching the broad ligament over the denuded surface, thus preventing subsequent adhesions.

The object of the operation is to reduce the resistance of the ovarian envelope by destroying its continuity.

If my theory is to be accepted and acted upon, it must be backed up by some practical proof, and I submit to you the following cases for this purpose:

(1) Mrs. S., æt. 34 years, consulted me on account of severe abdominal pain on both sides, but worse on the right. The pain had been present for eight years, and was so severe that she had been confined to bed before, during and sometimes after the menstrual period for the whole of that time. She described herself as a semi-invalid, and informed me that several medical men had advised her to have both ovaries removed. On examination, I found the uterus slightly enlarged and normal in position. There was no undue tenderness on bimanual palpation. Both ovaries were slightly enlarged and exquisitely tender. She volunteered the statement that my palpation of her ovaries caused the pain she complained of. She was still disinclined to permit an operation. She therefore tried hot douching and ichthyol tamponage for several weeks. As this had no beneficial effect, she consented to an operation. I found small cystic degeneration of both ovaries, with very much thickened *tunicae albugineae*. I had determined to deal with this case in the manner I have described, but only with one ovary and

[1] Read at a meeting of the New South Wales Branch of the British Medical Association on April 28, 1916.

to remove the other. The ovaries were similar, so that the choice of ovary to be left was a matter of little importance. I removed the left organ for two reasons. In the first place, she stated that the pain was more severe on the right side, a fact I did not wish to take advantage of; and, secondly, as I operate on the left side of the patient in pelvic cases, the left ovary lay more conveniently for removal. The right ovary was treated in the manner described above. She had her first menstrual period in hospital, and it was the first without pain for eight years. I saw her after the second, and she was still free from pain. Nearly five months after the operation, after four periods had taken place, she wrote to me from Sydney, telling me that she had had no pain since the operation, and that she was feeling as well as she had felt ten years before.

Within ten days of this operation, I had occasion to operate on a Mrs. W. for *retroversio uteri*, causing bladder symptoms due to pressure of the cervix. She had no pain, but constant bladder irritation, with great frequency of micturition. I performed a Gilliam operation, and, on examining her ovaries, found them full of small follicular cysts, worse than those in the last case, the organs being half as large again. They had very thin *tunicae albugineae*.

(2) Mrs. M., æt. 21 years, complained of pain in both sides during the past three years. The pain was gradually getting worse. It was seldom absent, and was increased before and at the beginning of the menstrual period. It was worse on the right side than on the left. She had had appendectomy performed. Examination caused extreme pain on both sides. I had the opportunity of seeing her frequently before she consented to have an operation performed. She had the look of a person suffering severe pain, and was drifting into a neurotic state. At length she agreed to submit to operation, on the understanding that both ovaries were not to be removed. At the operation, both ovaries were found to be cystic and to have thickened tunicæ. I removed the left ovary and freed an omental adhesion to the old appendectomy scar. I denuded the right ovary. This was fully four months ago, and I saw her within the last fortnight, when she told me that she was free from pain. On being questioned more closely, she admitted that she had had slight pain at the onset of the menstrual period. The bright and happy look she had compared wih her former appearance of misery, was very striking. Had I not dealt with this case in this manner, I would have had to resort to Kelly's method of incision and puncture, which, in my experience, has not been satisfactory. The examination of this patient before operation was attended with such pain in the ovarian region that palpation was impossible, but, on re-examination, a few days ago, of the denuded ovary bimanual palpation was indulged in without causing undue pain.

Shortly after this operation I again had an opportunity of inspecting two painless cystic ovaries with thin *tunicae* in a patient, Mrs. B., who had an acute appendicitis. On vaginal examination, before operation, I felt the ovaries enlarged, and, with the object of investigating their condition, I removed the appendix by a Battley's incision and found, as in the case of Mrs. W., that the ovaries were enlarged and cystic, but had a thin envelope. The patient had never experienced pain, except in this attack, which was typically appendical.

(3) Mrs. S., æt. 34 years, suffered for some years from pain in the lower segment of the abdomen on both sides. The pain was worse at the menstrual periods. The pain on the right side was more severe than that on the left. Both ovaries were tender and enlarged. At the operation, both were found to be cystic and the *tunicae* thickened. The left ovary was removed and the right treated by denudation. The pain is now absent, and no dysmenorrhœa has been noted during the two periods since the operation. These periods were the first which were free from pain for several years.

The result of the operation in these cases shows that the reduction of the pressure is followed by a reduction of the pain. This is also achieved by Kelly's method, but in my experience only temporarily. In treating the ovary by approximating the incised edges of the *tunica*, the surgeon leaves it in the same condition as before operation, except that the cysts are evacuated. Before long, however, the cystic pressure is as great as before, and the pain returns with its full violence.

Though I have not waited until I could place before you the history of these cases years after operation, I would like to point out that my operation removes the pressure in a manner which is much more likely to be permanent than the mere punctures of the cysts. In none of these cases did I puncture the cyst. The cysts were left as they were before the operation. In none of my cases was there any inflammatory adhesion.

I performed the operation only three times before coming to Australia. As I have not been able to hear of the results, and as I do not now have the same opportunity of seeing so many of these cases as formerly, I have ventured to bring the operation before you, unbacked by a long series of cases, but with sufficient practical proof to justify a further trial. The advantage of the operation over the only other satisfactory alternative—double oöphorectomy—is so obvious that it certainly deserves, and, to my mind, demands, an extended trial.

The lives of the women, whose cases I have related to you, were so intolerable on account of pain that they consented to an abdominal operation, and in two cases to the removal of both ovaries, if necessary. The fact that they were relieved without the removal of those organs points to the obvious benefits of the operation. Every year many thousand women are feeling the effects of an artificial menopause; and many children are lost on account of the removal of both ovaries for this condition.

Reports of Cases.

A CASE OF COAL GAS POISONING.

By E. L. Crowther, M.D., C.M. (Aber.),
Hobart, Tasmania.

The prognosis of carbon monoxide poisoning is usually held to depend on the intensity and duration of the acute symptoms in so far as life itself is concerned, and on the

length of the inhalation and constitutional peculiarities of the individual in so far as the completeness of the recovery is concerned. It is well-established that elderly persons reveal less resistance to the toxic effect of the gas than young or middle-aged persons. Claude Bernard first pointed out that individuals with impaired renal function usually succumb to relatively smaller quantities or recover less completely after short inhalations of low concentration of the gas than do persons with normal kidneys. Under ordinary conditions it may be difficult and perhaps impossible to determine the concentration of the carbon monoxide in the air respired by a patient, and when the practitioner is first called to the patient he is not prepared to ascertain the degree of saturation of the hæmoglobin with carbon monoxide. Even when a fatal termination occurs within a short time of the poisoning, the hæmoglobin gives up a considerable amount of the gas as soon as the patient is removed from the source of poisoning and brought into contact with fresh air. In view of the large amount of experimental data, it is safe to assume that under ordinary conditions, when a persons remains for some hours in a room with a gas-tap turned on, the concentration of the gas in the air suffices to induce a fatal poisoning. When an animal is exposed to over 1 volume %of carbon monoxide, the hæmoglobin is saturated to the extent of over 70% within a relatively short time. Haldane has found that 0.05% produces symptoms in man and 0.2% produces dangerous symptoms. When the degree of saturation of the hæmoglobin approaches 70%, life becomes impossible. Much lower concentrations, however, may lead to death.

Severe coal gas poisoning rarely leaves no traces in the central nervous system. Haldane described a few years ago a striking case, in which a woman was found unconscious in a room in a hotel in London, with the gas-tap turned full on. The initial symptoms passed off partially at first, but the patient soon relapsed into a state of coma, from which she died on the eleventh day, with signs of very marked degeneration of the higher centres. In this case, he demonstrated very marked degeneration of the white matter, with exquisite chromatolysis. More or less extensive capillary hæmorrhages are not uncommonly met in cases of delayed death. The following case is of interest, in view of the completeness of the recovery after a very severe poisoning. It was unfortunately impossible to ascertain the concentration of the carbon monoxide in the air of the room when the patient was discovered, or to determine the degree of saturation of her blood.

Miss N., aged 17 years, on going to bed turned out the gas at 11 p.m., but must have turned on the tap again unconsciously, so that it was open at the time she went to bed. At 8.30 a.m. next day she was found in bed insensible. The room was "full of gas." I saw her shortly after. Her face was flushed and her respiration irregular, slow and stertorous. Intense bronchial râles could be heard without the aid of a stethoscope. The pulse was thready and irregular. I performed artificial respiration by Marshall Hall's method for upwards of an hour. While this was being done, 10 or 12 ounces of red-stained mucus, of the consistency of thin cream, exuded from her mouth and nostrils. Although the condition improved, she did not regain consciousness until the following morning. I gave her plenty of fresh air, a cold douche and a saline enema by the rectum. Pituitary extract and strychnine were injected hypodermically, and she had nitrite of amyl to inhale. As soon as she was able to swallow, I gave her some calcined magnesia and lime-water. A full dose of castor oil produced a copious dark evacuation of blood and slime. This was followed by a marked improvement. From that time onward, she made a steady recovery, and is now quite well, save for a certain amount of sleepiness during the daytime, which is foreign to her usual habit of body.

When I saw her first, I did not think that she could recover. In spite of the severity of the acute symptoms and of the long duration of the inhalation, she not only overcame the immediate effects of the carbon monoxide, but escaped from the disastrous late effects which so frequently follow in the wake,

(1) RIGHT LARYNGOHEMIPLEGIA FOLLOWING A GOITRE OPERATION.

(2) RIGHT ABDUCTOR PARESIS FROM PRESSURE OF ENLARGED CERVICAL GLANDS.

By **L. G. Davidson, M.B.,**
Sydney.

Before the war broke out traumatic paralysis of a recurrent laryngeal nerve was confined to goitre operations. Since the war many cases have arisen from laceration of the nerve by bullets, or from fragments of shrapnel. The cases are interesting from the point of view of prognosis. The patient, if he is a teacher, a barrister, or a clergyman, wishes to know if he will be able to resume his old occupation, and if so, how long will it be before there is an improvement in the functions of respiration and phonation. By merely observing the condition two or three times, with the mirror, one cannot form an opinion of any value. The cases require to be under observation for at least 12 months, and it is difficult to get patients to attend regularly, even when it is costing them nothing. From the anatomical relations, injury to the right nerve in thyroidectomy should be more frequent than injury to the left, as the right nerve as a rule passes in front of the inferior thyroid artery, and the left nerve passes behind it. In its course in the neck the right nerve is the more anterior of the two. The causes of nerve paralysis coming on immediately after operation are bruising and pulling about the nerve during the manipulations, section of the nerve with the knife, and its inclusion in the ligature applied to the inferior thyroid artery. Paralysis may occur later on from inclusion of the nerve in the cicatrix. It is also stated that transient paralysis may result from the application of strong antiseptic solutions, such as phenol, to the normal uninjured nerve during the operation.

The following case, which I have seen many times during the last eighteen months, was caused either by section of the nerve, or its inclusion in a ligature. In a discussion on treatment reported in the February number of the *Journal of Laryngology*, the general opinion expressed was to let well alone, in cases of injury to the recurrent branch, and to trust to time, and to the compensatory action of the sound cord to effect improvement of the voice. The cases are of some importance, as is shown by the fact that paralysis occurs in about 10% of the patients operated upon. An abductor paralysis may be present from the pressure of the goitre without there being any loss of voice, or laryngeal symptoms whatever. This being the case every case of enlargement of the thyroid should be examined laryngoscopically both before and after operation. Cases in which there are enlarged cervical glands should be examined for a possible abductor paralysis, as a matter of routine. I find, in looking through the literature of the subject, that paralysis is usually accidentally discovered months or years after an operation for goitre. The symptoms are severe enough at the time to call for an immediate laryngoscopic examination, but as far as I know this is not done, and the patient is allowed to leave the hospital without the slightest suspiciou that the condition is serious.

Miss W———, employed in one of the Government offices, was operated upon in one of the large hospitals for exophthalmic goitre, in August, 1914. I learned some months after that the loss of voice occurred immediately after the operation, and also that as soon as she attempted to drink milk, or other liquids, a violent laryngeal spasm was set up, in which she thought she would choke. These attacks occurred three or four times daily, for a considerable time. The voice was reduced to a whisper at first, and afterwards became husky, feeble, and unmusical. It was also bitonal at times. She stated that she usually spoke as if she had a very bad cold, and her voice would suddenly alter its pitch and run up an octave higher. This bitonal quality must have been fairly frequent, as her sister imitated her by talking in an ordinary voice, and then ending with a squeak.

Owing to a feeling of choking, she could not tolerate the presence of a large throat mirror, and as she was very short of breath examination with a small mirror was only possible for a few seconds. Complete right

laryngo-hemiplegia was present. The right arytenoid was motionless, save for a slight twitch inwards from the action of the interarytenoid muscle. The cord was crescentic in shape, and lay motionless, in the position midway between that of quiet respiration and the median line. The tip of the cartilage was displaced forwards, which gave it the appearance of being larger than the sound one, owing to its broad concave posterior surface being visible. The action of the sound cartilage was vigorous on phonation, as it pushed the paralysed one aside, and passed in front of it. The sound cord approached the paralysed one on phonation, but it did not close the glottic chink, and to this may be ascribed the suffocating attacks after drinking fluids, and the feebleness and tonelessness of the voice. After twelve months the voice began to improve, and also the breathing. For a long while the respiratory function was performed badly, as well as the phonative. She could not explain things owing to breathlessness, and on reading out passages from letters at the office she would frequently pause in the middle of a word, in order to take a deep breath. She attempted to sing, but her singing voice made everybody laugh, "being funny, and like a person with a cold." The voice got easily tired, so she did not persevere with the vocal exercises suggested. The choking attacks gradually lessened in frequency and violence, but the juice of pears or pineapple always set up a spasm. Solids were much more easily taken. As she was in dread of the attacks, she learned to take fluids very slowly, and has persisted in this. There is still some exophthalmos present, and also a myopia of 2D, which was fixed up with glasses. On telephoning to me on April 27, 1916, I could hear her voice quite plainly. She could not raise her voice to a loud tone, but it was no longer bitonal, and she conversed quite easily and without any evident effort. It was fairly strong, and musical in quality. She could read out four lines of a newspaper "leader" without taking a deep inspiration. To an ordinary observer it would appear quite a natural voice. The twitch was still present in the paralysed cartilage on phonation, showing that fixation of the cricothyroid articulation was not present even after the lapse of 18 months. In phonation the sound cord completely closed the glottic chink, and it appeared injected possibly on account of having to perform double duties. One proof of the closure of the glottis by the sound muscles was the comparative absence of the suffocative attacks on taking fluids, as she had not had one for two months. In the time of incomplete closure they were of daily occurrence. The lessening of these attacks had given her great comfort bodily and mentally. The laryngeal muscles had thus settled down to the task of helping their comrades that had been put permanently out of action, and by a compensatory action, and a nice adjustment of the functions of respiration and phonation, had made a wonderful difference in the patient's voice and respiration. I can hardly believe that the singing voice could be restored in a case of laryngo-hemiplegia, but I have seen it stated that it is a fact. All attempts of this patient to sing have been ludicrous failures, and I should be very much surprised if she ever succeeded. While her voice is strong enough for all ordinary purposes, I feel certain that if she were a teacher, or engaged in any occupation where constant speaking was necessary, the huskiness and feebleness of the voice would soon return if the occupation were persisted in.

Case 2. Enlarged Lymphatic Glands in the Neck—Right Abductor Paresis.

May 24, 1915. J.F.: The patient is not short of breath, and there is nothing the matter with his voice in ordinary conversation. He has come to have his throat examined, as he is worried because he cannot shout out as loudly as he used to do. Many times daily, on endeavouring to shout out instructions to his fellow workmen at the wharf, his voice "breaks" or "cracks." Both sides of his neck are occupied by a string of enlarged lymphatic glands at the borders of the sterno-mastoid muscles; some of them are as large as a hen's egg, and one over the cricoid cartilage on the right side, is as large as a fair-sized orange. They are freely movable and painless. There are about a dozen of these enlarged glands. He has never paid any attention to this condition, and has no idea how long they have been present. On laryngeal examination, the cords adduct quite well on phonation, but on inspiration the right cord lags behind its fellow, and gets no farther than the cadaveric position. If the paralysis were complete the cord should be fixed in the median line. One has to make several examinations to make sure of an abductor paresis, and the best laryngoscopists occasionally show cases where the diagnosis is received with scepticism.

In this case no other cause than the obvious one, *i.e.*, pressure on the vagus, or on the recurrent branch by the glandular enlargement, had to be sought. He improved on specific treatment, and the glands diminished in size, but before I could watch the progress of the paresis the patient disappeared. The glands may have been removed surgically, and no doubt the surgeon will get the blame for any subsequent hoarseness.

PATENTED ENEMY PREPARATIONS.

We have received the following letter from the Registrar of the Pharmacy Board of New South Wales, and would direct the attention of medical practitioners to its contents:—

To the Editor, *The Medical Journal of Australia*, Sydney.
Dear Sir—

The Pharmacy Board of New South Wales discussed, at their last meeting, the proclamation of the Federal Government which makes it an offence, punishable by a fine up to £500, for any person in the Commonwealth to sell an article known under a name which has been patented by enemy's subjects.

There has been a considerable demand in the past for many well-known preparations which can be so described. As it is now entirely forbidden to trade in these goods, we wish to point out that it is advisable for medical practitioners to make themselves thoroughly acquainted with the drugs affected, and not to order them again under their former names. We have previously issued a card giving synonyms for the principal drugs of this kind, and for the benefit of the medical profession, we attach a further list, with the hope that doctors will make the fullest use of it, and so carry out the intentions of Government without any detriment to their patients. The prohibition came into force on the 12th April, so that the pharmacist is at present liable to the above fine if he handles such goods. A most complete list of synonyms for the various proprietary drugs (mostly of enemy's manufacture) will be found on pages 37-100 of the Australasian Pharmaceutical Formulary, which has been supplied to medical practitioners in this State.

The Pharmacy Board feels it is in the interests of all concerned that the matter should be prominently brought before the medical practitioners in your esteemed journal.

Yours faithfully,

A. FORSTER,
Registrar.

7 Richmond Terrace, Domain,
Sydney, 25th May, 1916.

List of Synonyms for Drugs Patented by Enemy subjects:

Albulactin	———
Apenta	Several Local and French Mineral Waters
Aristol	Any Iodoform Substitute
Aspirin	Acetosal
Antipyrin	Phenazone
Cystopurin	Hexamine (B.P.); Formin
Formamint	Several British Preparations, Formalin and Mint Lozenges
Helmital	Hexamine (B.P.)
Heroin	Aceto-Morph. Hyd.
Jothion	———
Jodipin	———
Lysol	Liq. Cresol Saponatis (B.P.)
Migrainine	Phenazone Caffeine Cit.
Mesotan	———
Neosalvarsan	———
Protargol	Silver Proteinate
Perhydrol	Hydrogen Peroxide
Pebeco Tooth Paste	Several Local Preparations
Sanatogen	Ceregen, Neurogen, etc.
Salvarsan	Galyl, etc.
Trional	Methyl-Sulphonal
Veronal	Barbitone (B.P.)

The Medical Journal of Australia.

SATURDAY, JUNE 3, 1916.

The Soldier's Heart.

Of the many chapters of the yet unwritten Medical History of the War, none will be of greater scientific interest or of wider practical importance than that dealing with the disorders of the heart. The fact that this chapter has been entrusted to Sir James Mackenzie is, in itself, a sign worthy of note. This chapter will probably stand in contrast to the majority of the others, in that its lessons will be applicable to the conditions of ordinary life and not be restricted to the artificial environments of modern warfare. It is not too much to hope that when the present devastation is over, a formula will be found which will render its repetition impossible. A century hence gas gangrene, the insidious infections of bullet and shrapnel wounds and the epidemic spread of dysentery and paratyphoid fever among vast masses of men on active military service may be of historic interest solely. The symptoms traced to the disturbance of cardiac function, on the other hand, will certainly remain a problem of actual importance. A discussion has recently taken place in the Therapeutic and Pharmacological Section of the Royal Society of Medicine on a condition known as the "soldier's heart" or the "irritable heart of soldiers." Sir James Mackenzie has analysed the clinical manifestations of a large series of cases answering this description, and has given an account of the various types and characteristics which will undoubtedly serve as a lasting basis for further investigations. It is true that others have handled the same problem before him. As long ago as 1864 the military authorities recognized that certain soldiers were rendered incapable of active service by this condition. As Dr. R. M. Wilson has pointed out, the theories put forward in regard to the nature of this condition have all been proved to be erroneous. The prominent point, which Sir James Mackenzie has brought into view, is that the cardiac symptoms appear to be the result of strain during infection in the majority of cases. The infection varies widely, and he has suggested that its effect on the heart may be either a direct one, with invasion of the heart muscle by the bacterium responsible for the primary condition, or an indirect one, in which the heart is poisoned by the chemical products of the bacteria situated elsewhere. He has shown that both in the case of the infected heart and in the case of the intoxicated heart, which has previously been affected with a chronic change, the predominating symptom is exhaustion. He has revealed two facts of importance. The first is that his study of these so-called soldiers' hearts has convinced him that the syndrome is but a part of a general condition. The second is that, in the course of treatment, active exercise can be indulged in without risk of exhaustion, if the pleasurable interest of the patient in his occupation can be awakened. He deduced from this that the predominant symptom of the soldier's heart is probably vasomotor in origin, due to irritation of the central nervous system. Other speakers emphasized the experience that the symptoms were especially common in young individuals, boys still in their teens, and that they bore no relation to courage or keenness. It appears that when a soldier is told by the regimental medical officer that he is suffering from a heart disease the prospects of relief are materially checked. The Imperial Government has been asked to provide a well-equipped hospital in which cases of this kind may be observed and where games could be employed as part of the treatment. Sir James Mackenzie has found that fishing, riding, shooting, golf, bowls, quoits and skittles awaken in the ordinary individual an interest sufficient to take the patient's mind off his bodily symptoms. The Military Medical Officers naturally aim at an early return of the men to the fighting-line, or, in the case of permanent incapacity, at securing their discharge at as early a moment as is compatible with safety. If the Commonwealth Government determines to follow the wise advice given by Sir James Mackenzie, it should be pointed out that, even when there is no prospect of the patient again being fit for military service, a marked economic gain would be effected by the timely and adequate treatment of the sufferer from the "soldier's heart" before he is finally allowed to return to civil life and civil occupation.

THE TREATMENT OF TETANUS.

Many years ago Kanthack taught that caution should be exercised in estimating the value of any form of treatment for tetanus, since the frequency of spontaneous recovery was difficult to determine. Continued observation has revealed some parallelism between the length of the incubation period and the termination of the infection. To-day opinions appear to differ as to the curative value of tetanus antitoxin, notwithstanding some very definite indications proceeding from the laboratory. Dr. A. T. MacConkey has published a comprehensive review of his own work and that of others,* with the view of inducing those who have the care of wounded soldiers to collaborate in a collective study of some points requiring elucidation. He shows with striking clearness that guinea-pigs, which have received one minimal lethal dose of tetanus toxin, usually die when antitoxin is administered subcutaneously as late as the forty-eighth hour after injection. The amount of antitoxin required to save the animal after 30 hours is 6,000 units. It must be remembered that 6,000 units is the quantity necessary to neutralize 6,000,000 lethal doses of toxin. When the antitoxin is applied between 18 and 24 hours after the injection of the toxin, 2,000 units suffice. The time-factor appears to be of considerable importance. Without antitoxin the guinea-pig dies between the third and the sixth day. Symptoms develope two days after the poisoning. In other words, when antitoxin is applied subcutaneously, the chances of recovery are extremely small if the treatment is begun after the symptoms have manifested themselves. Better results were obtained in a few experiments when the antitoxin was given direct into the spinal theca. Clinical experience has taught that tetanus toxin passes either through the lymph channels or along the axis cylinders into the spinal canal, and that the cerebro-spinal fluid of patients frequently contains a considerable quantity of free toxin during the early days of the manifest disease. It is known that antitoxin cannot pass into the spinal theca from the blood stream, and the logical conclusion would be that if antitoxin is to be used in the treatment of this disease, it should be administered by spinal injection. There is extremely little clear evidence whether this mode of treatment is actually responsible for the recovery of patients who have escaped death after a severe attack of tetanus. The most important point in this connexion would be the determination of the latest period after infection at which antitoxin can still prevent a fatal issue. So far no accurate knowledge has been accumulated in human subjects on this matter.

If it be permissible to apply the laboratory findings to the case of man, it would seem that the amount of antitoxin required to save the human patient after a single lethal dose of tetanus toxin would be about two million units. As has been stated above, 6,000 units are required for a guinea-pig weighing 350 grammes when the interval is as long as 30 hours. This amount is equivalent to 1,200,000 units for a man weighing eleven stone. But man is approximately twice as susceptible to tetanus as the guinea-pig. On the other hand, there is ample evidence that from 500 to 1,000 units usually suffices to protect a man against infection. Consequently, when a large number of men have to be dealt with, it is essential to consider both whether the prophylactic injection of antitoxin is more efficacious than the curative and whether the quantities required for either procedures are available. On the basis that, even when applied very early, at least 2,000,000 units is the smallest dose likely to effect a definite therapeutic result, 2,000 men could be protected with the same quantity of antitoxin as is required for the treatment of one. Moreover, we know that in the majority of cases the prophylactic injection of antitoxin prevents the development of the disease, while it is impossible to assert whether antitoxin can cure it when once it has broken out or not. It would seem that the incidence of tetanus in soldiers wounded during the fighting in Flanders and France has been considerably higher than 1 in 2,000. We would therefore conclude that in the present state of our knowledge it is wiser, more economical and more likely to do good if every man were to receive an injection of antitetanic serum as soon as possible after having been wounded. When Dr.

* *Journ. Royal Army Medical Corps*, March, 1916.

MacConkey has gathered more information on the important points raised in his article, it may be necessary to review the whole question.

AN EXCISE ANOMALY.

The governing bodies of the Australian Universities, the learned societies and many scientific investigators have asked the Department of Trade and Customs of the Commonwealth repeatedly to permit the use of alcohol free from excise duty in approved laboratories for the purposes of scientific investigations. Permission has invariably been refused. In the United Kingdom of Great Britain and Ireland recognized laboratories and institutes for research are allowed to store alcohol in bond for exclusive use within the laboratories. This favour has been greatly appreciated by workers in chemical, biological and bacteriological science. This freedom from excise has made it possible to carry on certain lines of research which were formerly closed, owing to their prohibitive cost.

It was pointed out by Dr. E. H. Embley, in the issue of May 20, 1916, that the Department of Trade and Customs had wisely conceded to chemists the privilege of excise-free alcohol for chemical manufacture since the outbreak of war. We understand that this privilege has recently been granted to the trade in Britain. While the use of alcohol which has not been denatured and on which excise duty has not been paid is granted to the manufacturer engaged in business for profit, its use is denied to the scientist who disseminates his discoveries for the benefit of humanity. The Department, however, does grant laboratories the use of alcohol denatured by wood naphtha and containing neither kerosene nor pyridine. Such alcohol can be used for many purposes in the laboratory, though it cannot replace pure alcohol for all requirements.

The argument in favour of the payment of excise duty is difficult to gauge, since the revenue accruing to the Treasury must be small. From the point of view of the scientist, the excise duty on alcohol is not unimportant, since the amount of money available for the maintenance of laboratories is so insufficient that research work is frequently interrupted owing to the absence of funds to pay the cost of its continuation. Very few institutions can afford to pay the excise on thirty-five gallons of 95% alcohol, which represents the amount required for ordinary purposes in a laboratory not engaged on work requiring the use of a large amount of spirit. So far, no scientist in Australia has been sufficiently wealthy to undertake work needing the free use of pure alcohol. Investigations of the medicinal principles of Australian plants have been much hampered through this disability. The free use of alcohol for extractions on the large scale has been quite impossible and much unnecessary labour and loss of time have been occasioned in devising methods for avoiding the use of alcohol.

We trust that the Department of Trade and Customs will regard favourably the representations from Australian scientists which are being put before it at the present time.

MALARIA IN RETURNED SOLDIERS.

The Minister for Defence has announced that certain of the recommendations of a conference held in Sydney on January 21, 1916, are to be put into force (see *The Medical Journal of Australia*, January 29, 1916, p. 106). It will be remembered that Surgeon-General Fetherston, several other army medical officers of high standing, Professor Welsh, Dr. Cumpston, Dr. Priestley and Dr. J. Burton Cleland discussed the question of the possible spread of malaria from soldiers returning from New Guinea and other malarial districts and recommended the disembarkation at Townsville of all soldiers suffering from malaria when returning from New Guinea to Australia, for observation and treatment. This is to be carried out. The second recommendation, to which effect is also to be given, is that all invalided and discharged soldiers at present in Australia, who have been infected with malaria, should be concentrated in one place for the purpose of instituting treatment. The Minister has determined that these men shall be subjected to a course of treatment of three months' duration, and that they shall receive pay during this period, notwithstanding the fact that they may have been discharged. The members of the Conference suggested that the assistance of the Pensions authorities be sought in this connexion. We understand that steps have been taken with this end in view. The last recommendation of the conference was that the treatment to be accorded to soldiers suffering from malaria should be officially ordered, and should be on the lines suggested by two members of the Conference, namely, Professor Welsh and Dr. Priestley.

WAR CHEST DAY.

The Committee of the Citizens' War Chest Fund are seeking purchasers for buttons at £500 a piece. They point out, however, that the buttons will not all be sold at that price. The minimum charge will be one shilling, but the purchaser may give as much more as he likes. The proceeds of the sale of these buttons will provide Australia's soldiers with those little comforts which are not in the official ration or supplies. The War Chest Fund is an organization which exists for any emergency arising out of the war. It has already achieved a great deal through the depôts established at Marseilles and Constantinople, and its activities have been greatly appreciated by those on active service. War Chest Button Day is on June 30, 1916.

THE TREATMENT OF SYCOSIS.

Dr. J. Forbes Mackenzie, surgeon to out-patients at St. Vincent's Hospital, Melbourne, writes that for some time past he has been using balsam of Peru in the treatment of sycosis and other beard irritations. He thinks that it may interest others to know that the condition responds better to this treatment than to any other he has tried. The balsam is applied by painting it on daily. In the last case in which it was used the sycosis cleared up in one week.

We note with great regret that Professor A. E. Barker died on April 8, 1916, of pneumonia. Professor Barker has filled the position of Consulting Surgeon to the Southern Command, with the rank of Lieutenant-Colonel.

Abstracts from Current Medical Literature.

PATHOLOGY.

(204) The Reducing Substance in Cerebro-Spinal Fluid.

Schloss and Schroeder (*Amer. Journ. of Dis. of Children*, January, 1916) agree with several other observers that the reducing agent in cerebro-spinal fluid is a fermentable dextro-rotary sugar, presumably dextrose, which is destroyed by bacterial growth in 24 to 71 hours. It is not pyro-catechin or a pyro-catechin derivative, which is unaffected by bacterial growth. This sugar content varies between 0.139% and 0.054%, and the normal variation in the sugar content of cerebro-spinal fluid is very close to that which obtains for blood, although there is no correspondence between the two in the individual case at a given time. In the cases of epidemic cerebro-spinal meningitis examined, the reducing agent was usually greatly decreased, and usually, though not invariably, increased with the improvement of the patient. In tuberculous meningitis, the dextrose percentage might be normal, slightly reduced or greatly reduced; the reduction occurred irregularly at some stage of the disease, but usually as the disease progressed. In meningitis due to other organisms, *e.g.*, streptococcus and the like, the reducing substance was greatly decreased or absent. In poliomyelitis the reducing power was normal in the three cases examined, but decreased in one case of polio-encephalitis. In two cases of cerebro-spinal syphilis, and in six cases of idiocy, the sugar content was within the normal limits.

(205) Natural Hæmolysins.

H. W. Wade has made a study of the hæmolytic action of fresh human blood serum on the erythrocytes of the sheep and the guinea-pig (*Journ. Medical Research*, March, 1916). He concludes that the hæmolytic action of human serum on the corpuscles of the guinea-pig depends on the presence of complement and a specific anti-substance. He finds that the anti-substance occurs with considerable regularity and uniformity of concentration. From an examination of 500 sera he considers that the hæmolytic combination for the corpuscles of the guinea-pig is much superior to that of the natural sheep system, since the latter appears less constantly and with greater variability of concentration. He discusses the application of these experiments to various methods of performing modified Wassermann reactions for syphilis.

(206) Trichina Larvæ in the Spinal Fluid.

A. R. Elliott reports the identification of trichina larvæ in the spinal fluid of a girl, aged 14 years (*Journ. Amer. Med. Association*, February, 1916). The patient complained of malaise lasting for one week. Soreness of the muscles, a moderate degree of fever and diarrhœa were then noted. Seven days later the patient awoke with severe abdominal pain, which was followed by vomiting. On admission into hospital in Chicago, she showed no œdema, cyanosis or jaundice. Rosered spots were scattered over the abdomen. There was general abdominal tenderness. A blood examination revealed a certain amount of chlorosis. The Widal test was negative. Ten cubic centimetres of clear spinal fluid was withdrawn, in which three actively motile trichina larvæ were found. A section of muscle fibres was removed, but no parasites could be found. The patient made a slow recovery.

(207) The Production of Experimental Purpura.

R. I. Lee and O. H. Robertson have prepared an antiserum against the blood platelets of the guinea-pig, and have studied its reactions with the platelets in the blood of the same animal (*Journ. Medical Research*, January, 1916). The antiserum has strong agglutinating and lytic effects, which are only produced in the presence of complement. The antiserum is specific, since it has no effect on the platelets from the blood of the rabbit. Injection of the antiserum into guinea-pigs, by the subcutaneous or the intraperitoneal route, has produced a condition similar to the acute form of *purpura hæmorrhagica* seen in man. There have been numerous and profuse hæmorrhages in the skin, abdominal muscles, intestines, heart, and uterus. The normal time for bleeding from a slight puncture has been increased from five to forty-five minutes. The coagulation time has not been lengthened. Multiple infarcts have been found post-mortem in the lungs. The spleen has been black or dark red, and the bone marrow of a deeper red than normal. Microscopical study of the hæmorrhagic areas has failed to show how the bleeding has been caused. No lesions have appeared at the site of the injection of the antiserum. The serum of guinea-pigs suffering from severe purpura has no effect upon platelets, either in shed blood or in the intact animal. Such serum has also failed to reproduce the condition of purpura.

(208) Gastric Mucosa Implanted into the Intestine.

G. M. Smith has transplanted flaps of the gastric mucous membrane into the large or small intestines of dogs (*Journ. Medical Research*, January 1916). Elliptical portions of the fundal region of the mucous membrane of the stomach, measuring 30 sq. cm., have been resected and implanted into the intestines of the same dog. The transplanted tissue has been removed for histological study four days, three months, eight months and fifteen months after implantation. No change has occurred until four months has elapsed. After that period certain areas in the graft have shown changes in the characters of the cells lining the peptic glands. The chief and parietal cells have disappeared and become replaced by an indifferent type of cell, resembling a pyloric cell forming mucus. After eight months this change has occurred over the whole of the surface of the graft. This transformation is regarded as a metaplasia.

(209) Cultural Experiments with Spirochaeta Pallida.

U. J. Wile and P. H. de Kruif claim to have transmitted experimental syphilis to five generations of rabbits by the successful implantation of spirochaetes from living paretic brain (*Journ. Amer. Med. Association*, February, 1916). The initial inoculation was made into the testis of a large rabbit. Two months later the testis was removed, and divided into two halves. One half was used to infect another rabbit. The other part was planted deeply in tubes of rabbit kidney ascitic agar medium. Six tubes were infected. Growth occurred in two tubes. The growth was visible to the naked-eye after two months. Pure cultures of motile spirochaetes were present. Subcultures were made, which showed growth in three weeks. A further successful subculture was made. The question of the existence of a neurotropic strain, with morphological characters different from those of ordinary spirochaetes is discussed. The authors draw attention to the extremely viable nature of their cultures.

(210) The Cultivation of Vaccine.

Edna S. Harde has succeeded in cultivating the virus of vaccinia in the cornea of the rabbit (*C.R. Soc. Biol.*, Paris, November, 1915). The virus dies out when inoculated into the kidney, heart or liver of the same animal. The virus also grows in the testis of the rabbit or guinea-pig. The virus, however, dies out in cultures made in the testis removed from the living animal and kept alive by the technique introduced by Harrison. The bodies of Guarini do not appear in the cornea after its inoculation.

(211) Myocardial Infarction.

H. T. Karsner and J. E. Dwyer have made an experimental study of the characters of infarction of the myocardium, of the regenerative changes in the wall of the heart and of the process of scar-formation (*Journ. Medical Research*, March, 1916). Ligature of the coronary artery in dogs gives rise to a localized area of congestion, œdema, cloudly swelling, hæmorrhage, fatty degeneration, granular necrosis of the cardiac muscle and necrosis of the interstitial connective tissue. The infarct that is produced has the fundamental characters of infarcts of the spleen, kidney and lung. The infarct in the heart wall is at first hæmorrhagic. Later it undergoes decolorization and cicatrization. The necrotic material is removed by liquefaction and by the activities of polynuclear leucocytes, fibroblasts, polyblasts and

multinucleated giant cells. The authors have not been able to obtain any satisfactory evidence of regeneration of the cardiac muscle cells during the stage of healing of the myocardiac infarct. The scar that is finally formed is produced by proliferation of the pre-existant connective tissue and blood vessels. This process shows no essential differences from similar cicatrization in other organs. Thirteen dogs have been used in this study.

PÆDIATRICS.

(212) Macewen's Sign.

Skull percussion was first referred to by Macewen in connexion with the symptoms and diagnosis of brain abscess. The sign is best determined by means of a stethoscope placed on the forehead, just above the base of the nose, the skull being tapped directly with the finger or hammer over the parietal region, beginning over the parietal boss, and gradually approaching the point of application of the stethoscope. The sign consists in a high-pitched, sharp, short, cracked-pot note, most distinct with percussion over, behind or below the parietal boss, and diminishing in intensity as the percussing finger approaches the stethoscope, Wilcox (*Arch. of Pediatrics*, December, 1915), after a study of skull percussion in a large number of healthy and diseased infants and children, comes to the following conclusions: (1) The skulls of children of various ages and development have percussion notes peculiar to the state of the cranium. (2) It is possible to establish a note normal to the various types of crania found in infants and children. (3) A positive Macewen's sign exists when variation from the normal note is found. It consists in a relative change rather than a definite condition common to all diseased crania. (4) The sign is better elicited by the stethoscope than by the unaided ear. (5) Increased clearness of the sound when percussion is carried out over the posterior portion of the skull, rather than near the stethoscope, is diagnostic. (6) The sign uniformly accompanies conditions of increased intra-cranial tension, and is not found unless this causative factor exists. (7) It is equally applicable to infants and older children. (8) It was present in 50 of 53 cases of tuberculous meningitis. (9) It was present in 17 of 18 cases of meningitis of other types. (10) It was present in all of five cases of poliomyelitis. (11) It was found to vary directly with the development and recession of cerebral symptoms as complications of disease not directly affecting the central nervous system. (12) It was present in 11 of 13 cases of pneumonia, in five of which lumbar puncture showed increased cerebro-spinal fluid under pressure. (13) The sign is uniformly lacking in children normal as to the brain and its coverings.

(213) Splenomegaly with Anæmia and Hæmorrhages.

J. Galloway records a rare condition in a child aged 8½ years (*Brit. Journ. of Chil. Diseases*, March, 1916). A swelling in the abdomen was noticed in July, 1913. In October an attack of jaundice followed, and in February, 1914, seven epistaxis. During 1914 the child had purpura and hæmatemesis with melæna. The spleen was markedly enlarged, and there was some enlargement of the liver. Ascites was present. A typical blood count was as follows: Red blood cells, 2,630,000; hæmoglobin, 30%; colour index, 0.5; leucocytes, 860. The differential count revealed 55% polymorphs, 35.5% small lymphocytes, 5% large lymphocytes, 3% large hyaline cells and 1.5% eosinophile cells. The Wassermann reaction was negative, and there was no history or indication of syphilis. On March 19, 1915, there was a sharp rise of temperature to 102°. During the following days the rise was slighter. On February 26 it rose to 106.2°. The fever was accompanied by some pain, with a little vomiting, but the child was not markedly ill. Three days later the fever disappeared. The child lost strength and the ascites increased rapidly. He died in March. The question of splenectomy was considered early, but was regarded as contraindicated on account of the enlargement of the liver and ascites. The author considers that the splenomegaly and anæmia were associated with portal thrombosis. He holds the view that the portal thrombosis was the primary cause of the condition.

(214) D'Espine's Sign in Childhood.

J. L. Morse has applied D'Espine's sign as a routine physical examination to 666 unselected children in his private practice, and, on investigating the results obtained, has drawn certain conclusions (*Amer. Journ. of Diseases of Children*, April, 1916). D'Espine's sign depends on the extension downwards of that timbre of voice that is heard through the stethoscope between the seventh cervical and the first dorsal vertebræ. D'Espine noted that in tubercular adenitis, when the stethoscope was placed in the subspinous fossa or intrascapular space, the voice sounds were conducted without modification to the ear, so that when the patient whispered a typical sound was produced and when the ordinary voice was used there was bronchophony. The author finds that D'Espine was correct in his claim that normally the change of voice occurs between the seventh cervical and first dorsal spines. *Chuchotement* or bronchophony heard below the first dorsal vertebræ is extremely uncommon in the children of the well-to-do classes. He detected it but 40 times in 666 children. It is rarely present in children under five years of age or over ten. In at least half the children in whom the sign was elicited, there was no justification for the diagnosis of tuberculosis.

(215) Thrombosis of the Lateral Sinus.

Peabody (*Pediatrics*, October, 1915) considers that thrombosis occurs in the lateral sinus not infrequently, and is often not diagnosed, the case being treated as one of malaria, enteric fever, scarlet fever with streptococcæmia, pneumonia, endocarditis or pyelitis. The disease frequently complicates purulent otitis media, and is its most common intra-cranial complication, whether the otitis is primarily acute or an exacerbation of a chronic disease. Pus in an acute otitis or mastoiditis anatomically is very close to the sinus walls, and infection and subsequent thrombosis are all the more likely to occur, because the dura covering the sinus is half the usual thickness, and because of the slight or even negative pressure of the blood in the sinus and jugular vein. The lowered resistance of the child, due to the original acute disease, is also a contributing factor. Infection may occur also by metastasis. Symptoms of the disease are due to a periodic discharge of septic material into the general circulation, and develope very quickly. Usually, there is a marked rise of temperature, preceded by a rigor, save in the case of children, and followed by a sudden fall and profuse sweating. The temperature fluctuations are irregular, occurring twice in 24 hours, or once in 48 at first; but later the rise and fall become periodic. Bacteræmia is always present, a streptococcus usually being found. Leucocystosis, with a high polynuclear count, exists. Headache, nausea and vomiting occur, and are associated with optic neuritis as the disease progresses. Tenderness over and behind the mastoid may occur, and a cord-like jugular in the neck may be detected. Metastatic abscesses usually appear late in the disease. All signs of a previous ear discharge may have disappeared days before the thrombosis sets in. The prognosis depends on the date of the diagnosis. The results of operative treatment are exceedingly good when the diagnosis is arrived at early.

(216) The Management of Enuresis.

Arthur Newlin (*Arch. of Pediatrics*, October, 1915) dispenses with all drugs in his treatment of enuresis. His method consists simply in anticipating the involuntary act, by a voluntary emptying of the bladder. This must be done regularly and systematically, and the attendants must carry out the necessary instructions. The child must be watched and treated day and night for the first 72 to 96 hours, for rarely after this is there need for exhaustive attention. For example, if enuresis occurs every two hours, the child must be lifted out for micturition every hour for twelve hours, the times of such micturition, or of involuntary acts of micturition, being carefully noted. At night, the child is lifted almost as frequently during the early hours, but after that every second hour usually suffices for the first night. On the second day, the time between the voluntary urinations depends on the chart record of the previous day, and may be lengthened. The "wet" hours of the previous day must always be anticipated by at least half an hour. Thus with each succeeding day the intervals can be lengthened, though particular attention to the "wet" hours of the preceding day must always be paid. Cure occurs usually before the end of a week.

British Medical Association News.

SCIENTIFIC.

A meeting of the New South Wales Branch was held on April 28, 1916, at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, Dr. Sinclair Gillies, the President, in the chair.

Dr. William Ritchie read a short paper on cystic ovaries (see page 447).

Dr. D. Kelly asked Dr. Ritchie if he would inform him whether any of his patients had previously been pregnant. He pointed out that painful ovaries were very common. It frequently happened that the pain existed until these young women got married and became pregnant. Nothing more was heard of the pain afterwards. He thought that in many cases the patients were neurotic. He agreed with Dr. Ritchie that painful cystic ovaries were those which had thick, hard coverings. He thought that Dr. Ritchie's operation was a good one.

Dr. Fourness Barrington expressed his indebtedness to Dr. Ritchie for having come so far to read his paper. He pointed out that every normal ovary was cystic. He was doubtful whether it was correct to speak of cystic degeneration when the cysts were small. He reminded his hearers that the normal ovary contained follicles which developed, matured, burst and degenerated. In regard to the operation, he thought that it would be as well to wait a little longer to ascertain whether the results would be permanent. He agreed that Kelly's operation was not a success. Dr. Ritchie's operation was certainly more logical. One of the difficulties in connexion with plastic operations on the ovaries, fallopian tubes or other appendages was that adhesions tended to form to the neighbouring structure. The fact that Dr. Ritchie sutured the broad ligament over the denuded surface got rid of this difficulty. He thought it quite probable that a thickened *tunica albuginea* might have a great deal to do with causation of the pain. In conclusion, he stated that the results of an operation were often very good for the first few months, but after a year or two they were not quite so satisfactory.

Dr. J. Crawford Robertson stated that a painful ovary was often the smallest and hardest. He was much impressed with the results of Dr. Ritchie's operation in the cases recorded, and considered that the operation was worthy of a trial. He asked Dr. Ritchie whether the operation of decortication, like that performed on the kidney, had been carried out on the ovary.

Dr. Sinclair Gillies was impressed with the originality of the operation.

In his reply, Dr. Ritchie thanked the members for the way in which they had received his communication. He informed Dr. Kelly that his first patient had had a baby three years before the operation. In reply to Dr. Barrington, he agreed that cystic ovaries might be normal, but his whole point was that the cysts in themselves had nothing to do with the pain. The pain was caused by the thickened *tunica albuginea*. He did not know whether the decortication had been performed on the ovary. He would not hesitate to apply it if there were any indications, but his contention was that his operation satisfied the requirements of the case. He had brought the operation at this early stage before the members, in order that they might test its efficacy.

MEDICO-POLITICAL.

A meeting of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on May 3, 1916, Dr. A. V. M. Anderson, the President, in the chair.

Dr. James Booth moved:—

> That, in view of the determination of the Minister of Public Health to introduce an amendment to the present Health Act, this Association recommends the Department to incorporate the chief feature of the West Australian Health Act, as assented to in December, 1915, and, further, that provision be made to safeguard medical practitioners under the Act.

Dr. Booth stated that the subject of venereal disease had been brought into prominence by the war, and that the present was the time for action. He contended that the Act in Western Australia had not been introduced to combat a social evil; it was rather a sanitary measure and not a police measure. The Act had been passed despite strong opposition from some women, backed by the clergy, who had held meetings and had tried to block the Bill in its passage through Parliament.

The Act provided for the treatment of venereal disease. He drew attention to Section 242b (see *The Medical Journal of Australia*, February 12, p. 148). The Section read as follows:—

> 242b. (1) Every person suffering from any venereal disease shall, within three days of his becoming aware or suspecting that he is so suffering, consult a medical practitioner thereon and place himself under treatment by such practitioner.
>
> Penalty: Twenty pounds.

This provision would apply whether the disease were in an infectious stage or not. He also drew attention to Sections 242d, 242e, 242f and 242g:—

> 242d. Every medical practitioner shall forthwith give notice to the Commissioner in the prescribed form upon becoming aware that any person attended or treated by him is suffering from any venereal disease in an infectious stage. The notice shall state the age and sex of the patient and the nature of the disease, but shall omit the patient's name and address.
>
> Penalty: Five pounds.
>
> 242e. If any patient who has been attended or treated by a medical practitioner for a venereal disease in an infectious stage shall fail to consult or attend such practitioner for a period of six weeks, and the practitioner shall not within that period have received from another practitioner a notice that the patient has changed his medical adviser, then such firstmentioned practitioner shall send to the Commissioner, in the prescribed form, a notice of the facts, stating the name and address of the patient.
>
> Penalty: Five pounds.
>
> 242f. Every medical practitioner who attends or advises any patient for or in respect of any venereal disease in an infectious stage from which the patient is suffering, shall, by written notice delivered to the patient, direct such patient's attention to the contagious character of the disease, and to the legal consequences of infecting others, and shall by such notice warn the patient against contracting any marriage until he is certified as cured.
>
> Penalty: Five pounds.
>
> 242g. When any such patient as aforesaid shall become cured of the disease, any medical practitioner shall, on being satisfied of the fact, give such patient a certificate of cure in the prescribed form.

When a medical practitioner was treating a patient suffering from venereal disease in an infectious stage, he would have to give notice to the Commissioner in the prescribed form. The name of the patient would not be given, but a number or initials. If the patient failed to attend for treatment for a period of six weeks, the practitioner would have to report the facts and to give the name and address of the patient. This provision was introduced to ensure that the patient would remain under medical treatment until he was cured. If he changed his doctor, the second doctor would be required to give notice to the first, who would be relieved of the duty of reporting. Patients suffering from venereal disease of an infectious kind would have to submit to medical examination. The patient was protected against any action of a drastic or unwarranted nature. The Commissioner was required to have some ground for believing that the person reported was suffering from the disease. The person would have the right to inspect all documents containing information upon which action may have been taken. If the person happened to be a female, she would be at liberty to consult a female practitioner and to be examined by her. The person could only be detained if suffering from the disease in an infectious form. An individual in that condition was not likely to suffer any injustice.

A Royal Commission had been sitting in England, and its report had just reached the State. There was no suggestion that notification should be introduced. This was due to the conservatism of the practitioners in England. They had modified their refusal to suggest notification by

stating that at present they did not consider the time opportune. They held that the people should be educated, and that provision should be made for the free treatment of the disease.

In Western Australia the Act provided that if a man asked a medical practitioner to treat him for venereal disease the latter was bound to do so. No person could plead that he could not afford to secure treatment.

The English Commission suggested that the Government, in conjunction with local authorities, should institute free treatment. This scheme had been begun in Sydney, but there had been such a rush that the patients had to wait out in the street.

According to the Western Australian Act, no quack was allowed to treat venereal disease. The medical practitioner alone was authorized to give this treatment. The provision had been added to the motion that the medical man should be safeguarded under the Act. Instead of a penalty of £5, he would suggest £100 or imprisonment. This would ensure that notification would be carried out and would prevent the possibility of collusion between the patient and the practitioner, who might be ready to pay such a small fine and save his patient from exposure. In the original draft the amount was £100. In the Norwegian Act the patient is required to notify every day. This would probably prove to be a nuisance. In this Act it was once a month. One provision of the Norwegian Act should be copied. The patient had to sign a form giving certain details, and in this way the medical practitioner was safeguarded against an action.

If the motion were carried, it would strengthen the hands of the Chief Secretary, who intended to introduce a separate Bill on these lines. In the interests of the nation, of the sufferers and of those yet unborn they would be doing good by assisting in the production of this measure, and he trusted that the motion before the meeting would be carried.

Dr. B. Crellin seconded the motion. His only doubt was whether the Western Australian Act went far enough. It dealt only with those suffering from active venereal disease. He was doubtful whether they should not consider the expediency of a compulsory legislation and periodical examination of prostitutes. He held the opinion that they should be examined by Government Medical Officers.

Dr. D. Rosenberg supported the motion. He said that greater powers should be given to health officers than they had at present. The £5 was large enough, as he did not believe that a medical man would appear in Court and pay £5 to save his client.

There were many loopholes for evasion in the Act. He read Section 242a:—

> 242a. (1) No person other than a medical practioner, or a person acting under the direct instructions of such a practitioner, shall attend upon or prescribe for any person suffering from any venereal disease for the purpose of curing, alleviating or treating such disease.
>
> Penalty: Fifty pounds, or six months imprisonment with hard labour.

This would not prevent the chemist or quack from treating venereal disease. A man calling on a chemist would say he was suffering from a discharge. How was the chemist to know that he was suffering from venereal disease? It was difficult enough for a bacteriologist to make a diagnosis. As the patient would know that he would be notified if he consulted a medical practitioner, he would go to the chemist every time. The only remedy was to prevent the chemist from treating anybody.

Dr. G. A. Syme pointed out that the principle involved had been approved at the Congress in New Zealand. Everyone who had had experience of this disease in Egypt, and who recognized that the men who had contracted the disease would return to Australia, would support steps being taken in every State to check the dissemination of this disease. He had discussed the provisions of the Act with Dr. Athelstan Saw, who was largely responsible for its introduction in Western Australia. The Act, as passed, was not as drastic as the Bill when first introduced. It had been toned down in its passage through the two Houses of Parliament. As it stood, it was an excellent Act, and, if enforced, would do a great deal of good. He considered that it would be better not to take up the other question at present, which was going to the root of the trouble. As a matter of fact, the Health Act of Victoria at the present time contained "C.D." provisions, but they were not enforced.

Dr. T. W. Sinclair admitted that the C.D. provisions of the Health Act were a dead letter, but he contended that the sections in the Victorian Act approached the subject from a different standpoint. He advocated the prohibition of the publication of advertisements which appeared in the daily, weekly and semi-religious papers. His experience of medical men was that they notified cases of infectious disease regularly and systematically. Notification was not so much the point in the Act as was the enforcement of treatment. This was a step in the right direction. He admitted that there might be errors in diagnosis. The motion had his entire support.

The motion, on being put to the meeting, was carried unanimously. The Secretary was directed to communicate the terms of the resolution to the Chief Secretary.

Medico-Legal

ELLERTON *v.* WREN.

On March 27, 1916, an action was begun in the Supreme Court in Brisbane, before his Honour, Mr. Justice Lukin, in which Dr. Henry Byam Ellerton, the Inspector of Asylums for Queensland, and Medical Superintendent of the Goodna Hospital for the Insane, sought to recover the sum of £10,000 damages for alleged defamation contained in certain articles published in the *Brisbane Daily Mail*, from John Wren, of Melbourne, at the time proprietor of the newspaper. The hearing occupied thirty sessions of the Court, and the verdict was returned on May 12, 1916. The articles complained of appeared on June 29, July 2, 20 and 21, and August 3, 9, 10, 17 and 21, 1915.

The plaintiff claimed that he had sustained special damages by reason of the publication, including expenses incurred for legal advice and assistance at a Royal Commission appointed to enquire into the truth of the statements contained in the publications complained of. The defence was based on the contention that the articles did not bear a defamatory meaning, that the publication was made in good faith, for the protection of the patients and attendants in the asylum and for the public good, and that they constituted fair comment regarding the plaintiff as a public servant in the discharge of his public functions.

It is impossible in the space at our disposal to reproduce all the evidence and speeches of counsel. In the following, the chief points brought out in evidence and some of the more relevant statements are given.

Mr. Feez, K.C., and Mr. A. D. Graham appeared for the plaintiff, and Mr. H. D. Macrossan appeared for the defendant. The case was heard by the Judge and a jury of four.

In opening the case for Dr. Ellerton, Mr. Feez spoke of the plaintiff's record as a specialist in psychiatry. He maintained that his conduct of the establishment had been exceptionally good. He stigmatized the statement that the patients were ill-clothed or ill-fed as an absolute lie. Referring to the sentence in one of the articles, that "the curable patient is tormented in a living hell," counsel doubted whether the individual, who had written it, could have been in his right senses.

Dr. Ellerton was in the witness-box for over six days. He stated that he had entered upon his duties as Medical Superintendent at Goodna on May 14, 1909. Shortly after, he had submitted a report to the Home Secretary, pointing out certain defects in the institution, and recommending additional accommodation for the patients, additional staff, better lighting installation, improved recreation arrangements, and other additions to the equipment of the institution. In regard to the results obtained at Goodna, he pointed out that the percentage of recoveries was influenced unfavourably by the number of senile patients received from Dunwich. He detailed the means he had introduced to enable him to control the progress of the patients. He denied that his whole time was taken up with administrative duties. He usually went round all the wards five times

a week, while on the sixth and seventh days he would go through some of them. He supervised the work of his medical officers. He did not operate himself, but often gave the anæsthetic. A complete record of each patient was kept. On admission, each patient was washed and put to bed.

His salary was £1,050 per annum, with house, garden produce, fuel and lighting. His expenses connected with the Royal Commission were £325. Dr. Ellerton denied categorically the allegations contained in the articles. In regard to the food distributed to the patients, Dr. Ellerton said that it was untrue that it was not hot or that it was uneatable. The patients were not compelled to work. When they undertook work they had their meals in the house where they worked, and received money gifts. The patients were not allowed to roam about unprotected. The windows in the refractory ward were often broken, but the patients, who were as hard as nails, did not suffer from the exposure. The statements made in regard to the mattresses standing in water was untrue. If the rain came in, it was the duty of the attendants to mop the water up.

Witness stated that the attendant Morris had been suspended for not answering the head attendant when the latter knocked at the door of the storeroom, and for inveigling another night attendant from his ward at night-time. An enquiry was held and Morris was reinstated. The whole matter was one of discipline. He had no intention to victimize Morris.

In reply to Mr. Macrossan, Dr. Ellerton stated that No. 1 ward was unsatisfactory. No complaints had reached him that the hot-water apparatus was out of order. After he had learned of it he had the apparatus repaired. The building was an old wooden one, and, consequently, it was quite impossible to keep it free from bugs. He admitted that he had suspended an attendant, who, he thought, was associated with the publication of the articles. He considered that the man's influence was detrimental to the welfare of the institution.

Counsel for the defence pressed Dr. Ellerton to express an opinion in regard to the late Dr. O'Brien. Witness appealed to his Honour, but was told that, however undesirable it might be to introduce the name of a doctor who was dead, it was necessary to answer the questions. Dr. Ellerton did not blame Dr. O'Brien. They were not friends. He believed that Dr. O'Brien knew something of the origin of the articles. In witness's opinion, Dr. O'Brien was seeking to stir up trouble in the institution, with the object of causing witness to lose his position. He also thought that Dr. O'Brien and certain attendants were engaged in a conspiracy to injure him.

Dr. Ellerton gave evidence at considerable length concerning the physical and mental condition of the patients, the care given to the patients, the classification of patients and the food supply. Certain patients suffered from syphilitic affections, but they were not infectious or contagious, and no risk was run by the other patients. Witness was pressed with questions regarding the number of dirty patients, who had to be washed, in one particular ward. Counsel cross-examined the witness in regard to the supply of milk to the patients, and attempted to show that the patients received, on an average, one-twentieth of a pint, while 31 quarts were supplied to six officials. Witness explained that some of the milk was supplied to the kitchen for use for afternoon tea, while the milk for sick patients was obtained from the wards. Counsel asked a number of questions concerning witness's opinion as to the extent of the conspiracy and as to the persons involved. Witness refused to be drawn in connexion with certain individuals, but admitted that he had accused some of the attendants with being in the conspiracy. The reason he had taken the action was to clear his professional name.

Several attendants gave evidence to the effect that, while the institution was overcrowded, the allegations that patients were shockingly neglected, that there was a shortage of clothing and bedding, that the patients did not get enough food, that the food was unsuitable or unwholesome, that patients had been bitten by rats, etc., were untrue. There were rats in the building, and bugs and lice were seen. Evidence in regard to the bathing of the patients, the supply of hot water in the wards and the difficulty in preventing patients from getting pediculi in their hair was also given by attendants and nurses.

In his evidence, Dr. McEvoy gave a general denial to the allegations contained in the articles. He held a high opinion of Dr. Ellerton as a psychiatrist. His evidence in chief confirmed in many particulars the evidence of Dr. Ellerton. On being cross-examined by Mr. Macrossan, he admitted that he had had no experience of mental work before he entered the Goodna Hospital. Counsel failed to obtain an announcement from him as to whether he intended to take action against the defendant. Up to the time of the publication of the articles, he had held a high opinion of the attendants, Morris and Falvey. He denied that he had used the asylum drugs in his private practice. Dr. Caldwell had supplied the drugs used. The major part of his outside practice was obstetric, and, consequently, he did not use many drugs. The value of the drugs used in the practice did not exceed £6 per annum. The drugs had been ordered and put into the dispensary, and he claimed that more had been put in than he had used. He regretted that he had previously held an unfavourable opinion of Dr. Ellerton.

Witness denied that there had been any special cleansing of the institution because of the articles or because of the Commission. He admitted that he had said that he would not put his hat on a patient's bed, but it was untrue that he had said that he had seen 20 bugs at one time on a bed. He denied that he had ever been incapable of carrying out his duties in the asylum.

The remainder of the plaintiff's case consisted in the evidence of attendants and nurses, who denied the truth of the various allegations.

The defence relied largely on the evidence of the reporter employed by the *Brisbane Daily Mail*, three attendants and Dr. Hemsley. The last named stated that he had acted as locum tenens for Dr. O'Brien from the beginning of August, 1914. He was at the hospital for three months and one week. He had no experience of psychiatry. His duties included the controlling of the certificates accompanying the patients on admission, and the keeping of the case records. He stated that he treated the patients for organic disease and not for their mental affections. He interviewed Dr. Ellerton every morning before he went round the wards with the matron. He had only met Dr. Ellerton once in the wards, when Dr. Ellerton had given an anæsthetic at an operation. He had applied more frequently to Dr. McEvoy than to Dr. Ellerton for assistance in connexion with the work. He was not able to diagnose with certainty the various forms of insanity. He parted on good terms with Dr. Ellerton. He considered that the patients' condition was bad, because nearly every female patient had nits in her hair. He had spoken to Dr. Ellerton about it, and the latter had said that it was very difficult to keep lice down. He had seen bugs. On one occasion he had refused to examine a patient at night-time until she was clean. He had seen at least a dozen bugs scatter when he came to the patient's bed. He had not seen any attempt being made to eradicate the bugs.

The witness stated that he did not consider Ward Ia fit for human inhabitation. He stated that he considered that the private practice of any doctor on the staff interfered with the work of the institution. He gave evidence in regard to having attended Dr. McEvoy when the latter was suffering from hallucinations. He stated that Dr. Ellerton had remarked that Dr. McEvoy enjoyed himself too much when he left the hospital. Witness denied that he had spoken to the reporter of the *Daily Mail* or that the articles could have been written on information obtained from him. He expressed the opinion that some of the patients should have been discharged. He complained that Dr. Ellerton's charge that he was conspiring against him was calculated to do him harm professionally, and admitted that he was then not on good terms with Dr. Ellerton. Counsel for the plaintiff sought an explanation for the difference between the evidence he had given in Court and that he had given before the Commission. Witness considered that his evidence given in the two places was practically the same. He pointed out that he was not asked to go into detail at the Royal Commission. He stated that he had been a close friend of Dr. O'Brien ever since he had been in Queensland.

Philip Champion de Crespigny stated that he joined the staff of the *Brisbane Daily Mail* in April, 1914. Mr. Fox, the Editor, told him that certain sensational statements had been made to him about the management of the Goodna Asylum, and asked him to use his judgement whether the case should be followed up after he had interviewed a Mr. Barry. Witness saw Mr. Barry, who said that the patients were very dirty, and were covered with vermin. Barry suggested that witness should accompany him to the asylum. This was done. They went to Dr. O'Brien's house. Dr. O'Brien was asked whether he would make any comment or give any information in regard to the alleged mismanagement of the institution. Dr. O'Brien said that he could not discuss the matter. Witness asked Dr. O'Brien whether the attendants, Morris, Tarmey and Falvey, were trustworthy and truthful men, and Dr. O'Brien had replied that they were men of excellent character and were thoroughly to be depended upon. Barry had supplied the names of the attendants. After they left Dr. O'Brien's house, they met the three attendants near a gully. The attendants got into the car and they all drove to Ipswich. During the drive and at an hotel in Ipswich, the attendants gave witness information concerning the asylum. Witness took notes and cross-examined the men closely. He was satisfied that the men were sincere. He promised to do his best to have a Royal Commission appointed. The statements made, on which he based the article of June 29, were as follows: The patients had not sufficient clothing; the bed clothes were insufficient; the wards and the patients were covered with vermin; the food was bad and inadequate; the medical staff was inadequate to cope with the work; Dr. Ellerton's time was absorbed in administrative duties, which did not leave him free to use his ability as a specialist in mental diseases; Dr. McEvoy had a considerable outside practice, which interfered with his work; Dr. Caldwell had, about two years previously, fallen from his horse and had become mentally deranged, and, as a consequence, he was of no use as a physician; Dr. McEvoy was permitted to absorb the services of three attendants in carrying out his own private practice; Dr. McEvoy used the asylum drugs in his private practice; there was no proper isolation of patients; patients with syphilis, cancer, skin diseases and other contagious affections occupied the same wards as other patients, and used the same towels, eating and drinking utensils; there was no treatment for insanity, the only medical aid being when inmates hurt themselves or caught typhoid fever or other illnesses; the sanitary arrangements were very poor, and typhoid fever had consequently resulted on several occasions. Once when Dr. Ellerton was away, 25 patients were ill with typhoid; the place was overrun with rats, and patients were frequently bitten while they were asleep. Once, during Dr. Ellerton's absence, a rat gang had been brought in and 1,700 rats had been killed. The place was still alive with rats; a great deal of money and patients' labour had been expended on the construction of a first-class cricket ground and on beautifying the exterior of the institution, while the interior and that part of the administrative department which was most closely associated with the welfare of the patients had been neglected; £450 had been spent on a motor-car, which was rarely used for the patients; £2,000 had been spent on a recreation-hall, which was unnecessary; some of the wards were terribly overcrowded, and one had been condemned, although it was still occupied by a large number of patients; patients, on admission, were placed among the worst type of patient, and were kept in surroundings which were calculated to do harm; the attendants were overworked, in certain cases they worked 15 hours a day and 56 to 65 hours a week, although 8-hour shifts were practicable; the attendants were forced to eat their meals surrounded by shelves on which were stacked soiled garments and bed clothes; the patients jeered at the attendants and threw things at them while they were eating their meals; the sanitary cart and the breakfast van frequently went round the grounds together, and had collided; some of the patients had only a square of canvas to cover themselves; the windows of the cells were broken and the rain frequently came in. The men also told him that nine persons had keys which gave them access to the storeroom, and that shortages were common. Nine were said to have been employed in generating power for the electric plant, and not more than 30 lights were burning at night. They also told him that pneumonia had resulted from insufficient clothing, and that a patient with enteric fever had been removed from a bed and another patient was placed in the same bed and died within a week. The men informed him that old men and young boys were mixed indiscriminately, and unnatural offences were not uncommon. Inmates of opposite sexes mixed in the grounds without supervision. He was further told that in one male ward there were 147 patients, and they had to be bathed in one bath within one hour. About 30 of these patients were dirty. The same water was used over and over again. In a female ward, only one bath and one towel for all the patients were provided. He was told that one patient had been left for 36 hours with a feeding-tube in his mouth, and another had been left without food for some days.

Witness was then examined in regard to the information on which he based the allegations contained in the article. The witness could not remember any specific instance having been quoted of patients having been tortured to death. The article was based on the statements made to him by the three attendants. On July 18 he paid a visit to Goodna after dark. One of the three attendants met him at the station, and they were joined by the two others at the asylum. All four entered, and he was shown some of the sanitary arrangements, and the female bath in the closed-in lattice on a verandah. Tarmey took him through Ward IV., and he went into the room where the attendants had their meals. He saw a boy, whom he took to be not more than five years of age, sleeping between a man and a patient, who looked like a Chinaman. Tarmey handed him a piece of bread, which he said was a fair sample of what the inmates had to eat. It was hardly better than raw dough. He threw a piece at the cockroaches, and it flattened on the wall. He visited the two buildings which he was told were the refractory wards. Tarmey told him that at night there was only one attendant on duty in the two buildings. In one cell he found a man dressed in a short shirt, dancing and shouting. The floor was in a filthy condition, and on it was a piece of canvas, the only bedclothing. The window was broken, the walls were dirty, and there were signs of vermin. As a result of this visit, he wrote the article which appeared on July 20. Witness was not aware that there was any sewerage system. He had been told that undue pressure had been brought to bear on certain attendants to sign a document supporting the management. Witness considered Dr. Ellerton's reply to the allegation misleading, as it inferred that only senile men and boys slept in the dormitory, whereas witness had seen patients who were neither boys nor old men in the ward.

In explanation of the statement printed that Dr. Ellerton had admitted many of the most serious charges, de Crespigny referred to certain passages in Dr. Ellerton's report, and stated that he interpreted these passages as admissions. He did not blame Dr. Ellerton. The Judge asked him why he had not said so, but the witness evaded the question.

On being cross-examined, the witness maintained that he had not laid himself out to be as lurid as possible. He was closely questioned in regard to "sensationalism" of the *Daily Mail* after John Wren bought it and the Editor, Mr. Fox, with it. He stated that an incident connected with the Patriotic Funds had arisen from errors in facts. He admitted that the paper fell in very badly over the articles referred to, and that the apology made by Wren was most abject. He also admitted that the paper had been carrying on a gambling business until stopped by the authorities. Witness had not considered it necessary to have gone to Dr. Ellerton before writing the articles. He had gone to Dr. O'Brien, who would not say anything. He did not consider it mean and underhand to go through the wards secretly at night time. Barry had told him that Dr. O'Brien was always quarelling with Dr. Ellerton, and that he was disgusted with the conduct of the institution. Witness considered that he was justified in making sweeping statements after a partial inspection of two wards out of the 18. He saw enough to condemn the administration.

Witness admitted that part of one of the articles had been eliminated by the Editor. He also admitted that it was not true to say that the asylum was managed with no regard to the well-being of the inmates. It was not a true deduction that one doctor was left to serve the needs of

1,400 patients suffering from all kinds of diseases. He attempted to justify the contention that once a man had been admitted to Goodna, there was an end of it. He maintained that Dr. Ellerton had no time to treat patients, that Dr. McEvoy had little time for professional work in the institution, that Dr. Caldwell was in a bad state of health, and that Dr. O'Brien had so much to do in connexion with the organic ailments of the patients, that he had no time to attend them for their mental affliction. The result was that a patient whose condition might have been curable, would get no treatment, and would consequently remain in the asylum for the remainder of his life.

Witness stated that he had not written the article which appeared on August 10. At first he denied that Dr. Ellerton was referred to in the sentence that "the management was accused of gross cruelty." Later he admitted that this was so. His replies in regard to Dr. O'Brien were indefinite.

The evidence of Morris, Tarmey and Falvey was of considerable length. Morris repeated a number of statements concerning the wards and the patients that he had made to de Crespigny. He adhered to the statement that in No. IV. ward, where there were 174 patients, there was only one bath and that 30 patients were bathed in the same water. He also maintained that the attendants had to use the same eating utensils as the patients. He stated that he knew of one man who had become infected from a patient in this way. Witness admitted that he had told de Crespigny that No. I. ward was the admission ward. He did not mean that all patients were admitted into this ward. He had also told him that there was no hope of recovery. If a patient got better, it was in spite of the lack of medical treatment. He gave some examples to illustrate that patients were being tortured to death. One patient had been left without treatment, in spite of the fact that the doctors' attention had been called to the man's condition. Witness had no food for another patient, who could not take ordinary food. This man actually died of starvation, but witness could not say in which ward. The windows of the refractory cells were broken, and driving rain came in. The mattresses were soaked, and the water ran into the passage when he opened the door. He denied that he had induced Dr. O'Brien to enter into a conspiracy. He had never had a private conversation with Dr. O'Brien.

Tarmey also gave in evidence his account of the wards and patients in the asylum. Under cross-examination, he admitted that he had not considered it necessary to tell de Crespigny of the excellence of the new wards. Witness admitted that the bathing was not very bad in four wards, and that it was good in four other wards. He admitted that he had said at the Commission that the food was not deficient, either in quantity or quality. He stated in his evidence in Court that it was deficient. He had told de Crespigny that one man had died of pneumonia through insufficient clothes, but had not told him that this patient had refused to keep his clothes on, and had escaped naked. He also gave some information in regard to two typhoid patients, but counsel showed that one of these patients was not suffering from enteric fever. He maintained that the patients were left without milk at night-time, but the book showed that on the day referred to, 64 pints of milk went into the ward, and that there were only three sick patients there. He did not tell de Crespigny that the patient, who was put in the bed previously occupied by a typhoid patient, had typhoid and died of it. He told him about the system. The man actually died of general paralysis of the insane. He admitted that he had misled de Crespigny in regard to a petition. He stated that the motion denying the charge was rejected by 49 votes to 2. The motion was not put to the meeting. Witness stated that the doctors did not find time to attend to the patients. His Honour pointed out that Dr. Hemsley had said that what he had to do took him about two hours. Witness had not reported any of the defects he had spoken of.

Falvey also gave an account of what he told de Crespigny. Witness said that it was untrue to suggest that he had met de Crespigny at Dr. O'Brien's house. He had never seen either Morris or Tarmey at Dr. O'Brien's house. He arranged de Crespigny's visit with Barry. He met him at the station. Morris was there when he arrived, but left immediately. De Crespigny, Tarmey and he crossed the bridge, and he left the others at the drive. Witness was reprimanded by the Judge in connexion with his replies to questions concerning a charge that he had sold some medicine to a certain woman. He denied that Dr. Caldwell had put drugs to the value of £23 into the dispensary. He maintained that more asylum drugs were used for the outside practice than for persons inside the institution. He maintained that Dr. Ellerton, who was an expert, never applied his skill to the patients. He had never seen it. He admitted that he did not know what treatment should have been applied. Witness said that de Crespigny was wrong in saying that he went with them to the cricket ground and to the sanitary arrangements. He denied having been on intimate terms with Dr. O'Brien. He had seen seven cases of typhoid fever in Ward VI. He admitted that it was unfair to have misquoted Dr. Ellerton's report concerning typhoid fever. Witness stated that Dr. McEvoy drank rum in the surgery. He had not told de Crespigny that the patients were being tortured into the grave.

Other witnesses, including nurses and attendants, supported the evidence of the witnesses for the defence. Some of the nurses introduced evidence in regard to cruel treatment by another charge nurse. The witnesses had not reported any of the defects to the Medical Superintendent.

The speech for the defence consisted of a review of the case, for the purpose of showing that the defendant had acted in good faith, and had taken the precaution of employing men of experience and judgement. Counsel contended that Dr. Ellerton had not suffered any official damage.

Mr. Feez contended that the articles were written without foundation in fact. He claimed that there was no evidence that Dr. McEvoy had not done his work well. He discussed the evidence in regard to the alleged conspiracy, and maintained that there was no escape from the deduction that Dr. O'Brien had been working in unison with the three attendants. He dealt at great length with de Crespigny's evidence.

His Honour Mr. Justice Lukin began his summing up on May 11 and concluded at noon on May 12. In regard to the evidence of the attendants, he said that the jury would have to determine whether they were humane men, who were prepared to sacrifice their interests for the welfare of the patients, and whether they had acted in a straightforward manner. He pointed out that Morris had admitted that he had misled de Crespigny in one particular. Morris had also misrepresented what had taken place at the meeting of the attendants when the articles had been discussed. That was a pure fabrication. Other statements by Morris had been contradicted by other witnesses. His Honour considered that Morris's conduct in the Court was such that he thought that the jury should wipe his evidence out altogether. In regard to Tarmey, who had stealthily introduced de Crespigny into the asylum, his Honour said that he used to go on a tour of inspection to other wards after he had finished his night's work. This tour might be called by a more offensive term. Many of the complaints he communicated to de Crespigny were not entered by Tarmey into the asylum books. Tarmey had not told de Crespigny that food had been left beside the patient who was said to have been left without food for 36 hours. Tarmey's fencing about the matron at the attendants' meeting was notable. Tarmey had been a fool, and the complaints he had made to de Crespigny would not stand investigation. He then turned to Falvey's evidence. His Honour said that this witness had been a personal friend of Dr. O'Brien. They knew Barry, a publican, and this led to the series of "accidental" meetings, at which the information was given to de Crespigny. This information was the basis of the articles published. His Honour regarded the evidence about Dr. McEvoy and the drugs as a sample of the evidence given by these witnesses. He asked the jury whether they could believe these men. In the next place, he called attention to the demeanour of some of the nurses who went into the witness-box for the defendant. One attendant, named Kelly, was a very different man from the three. He admitted that he felt sore because Dr. Ellerton had placed another attendant above him. Though Kelly was outspoken and almost impertinent at times, he did not go about surreptitiously at night.

He spoke of Dr. Hemsley's evidence as revealing that there was some misunderstanding. He had admitted a great many things highly creditable to the management of the institution, and he had praised Dr. McEvoy's work. He then dealt with the witness de Crespigny. He asked the jury to consider whether this man had given honest testimony and whether he had acted honestly. He had admitted that the press often got untrue statements. Should he not have gone to the Minister and obtained the records? Barry knew of the quarrels between Dr. O'Brien and Dr. Ellerton. De Crespigny had written the first article without attempting to verify the statements. Surely an honest journalist would have preferred to make enquiries by going through the wards in an open manner, and then to tell the truth. In regard to the allegation about the boy sleeping next to a Chinaman, de Crespigny excused the shuffling attitude of the paper, claiming that it was fair journalism. The witness had admitted that it would have been honest journalism to have admitted that the paper had made a mistake. He had also admitted that the statement regarding new patients was not quite true.

The appearance of the headline "Principal Charges Admitted" was part of the campaign to force the appointment of a Royal Commission. Did the jury think that if the truth had been told, the Commission would ever have been granted. On analysis, de Crespigny had admitted that the principal charges had not been admitted by Dr. Ellerton. His Honour pointed out that the proportion of recoveries at Goodna was very high, and yet it was claimed that there was no hope for any patient entering Goodna. He asked whether there was any evidence that the patients were being tortured into their graves. Statements had been made by de Crespigny, which he must have known were untrue. An example of this was the statement that there was only one medical officer to look after the inmates. In conclusion, his Honour directed the jury in regard to the question of damages.

The jury were asked the following questions: (1) Were the matters alleged defamatory? To this the reply "Yes" was given. (2) Were the matters alleged published in good faith? And for the public good? And in the course of and for the purpose of the discussion of a subject of public interest, the public discussion of which was for the public benefit? The jury replied in the negative to these questions. (3) Were the allegations of fact on which the comments were based true? The jury found that they were not. (4) Did the defendant honestly believe the truth of the facts on which the comments were based? The jury held that he did not. (5) What damages, if any, should be granted? The jury assessed the special damages at £325 and the general damages at £3,000.

An order was made for the amount of the verdict, £3,325, and cost for 31 days, exclusive of jurors' fees.

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending May 20, 1916:—

	Metropolitan Combined Districts. Cs.	Dths.	Hunter River Combined Districts. Cs.	Dths.	Remainder of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever ..	13	2	1	1	24	5	38	8
Scarlatina	57	1	2	0	112	1	171	2
Diphtheria	71	3	10	0	119	6	200	9
C'bro-Sp'l Menin.	*1	1	—	—	—	—	1	1
Infantile Paralysis	2	0	1	0	1	0	4	0
Pul. Tuberculosis	37	5	3	0	†		40	5

* This case occurred in the Infants' Home at Ashfield.

† Notifiable only in the Metropolitan and Hunter River Districts.

There were seven cases of small-pox reported from Narrabri.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending May 21, 1916:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Diphtheria	98	6	59	4	157	10
Scarlatina	22	0	29	1	51	1
Enteric Fever	5	0	19	0	24	0
Pulmonary Tuberculosis	20	11	6	5	26	16
C'bro-Spinal Meningitis	7	—	9	—	16	—

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending May 20, 1916:—

Disease.	No. of Cases.
Pulmonary Tuberculosis	11
Enteric Fever	15
Diphtheria	34
Scarlatina	10
Infantile Paralysis	2
Ankylostomiasis	1
Erysipelas	1

INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the week ending May 13, 1916:—

Disease.	Perth. Cases.	Fremantle. Cases.	Rest of State. Cases.	Total. Cases.
Enteric Fever	3	0	5	8
Diphtheria	4	1	10	15
Scarlatina	0	0	3	3
Pulmonary Tuberculosis	0	9	1	10
Infantile Paralysis ..	0	0	1	1
Meningitis	0	0	2	2

Naval and Military.

In the 171st casualty list, issued on May 25, 1916, the names of Captain W. J. Stack and Captain W. A. Harrison are included among those ill in hospital. In the 172nd list it is announced that Captain C. Retallick is ill in hospital.

In the issue of the *British Medical Journal* of April 15, 1916, it is announced that Lieutenant-Colonel Robert Jones, R.A.M.C. (T.) has been appointed by the War Office Inspector of Military Orthopædics. The recognition by the Imperial Authorities of this important branch of surgery is a matter for satisfaction. We again urge the Commonwealth Authority to take this matter into consideration, and to make adequate provision for an organized and systematic orthopædic treatment of soldiers who have suffered injury to bones, joints, muscles and nerves.

A herbalist of the name of P. Kugelman was fined £10 and costs for having advertised that he was prepared to give medical advice. The Medical Board of Western Australia undertook the prosecution, and the case was heard at the City Court, Perth, on May 6, 1916. The defendant contended that he had not represented himself as a registered practitioner and that there was nothing in the advertisement complained of which would lead people to believe that he was registered or qualified. Notice of appeal was given.

Books Received.

JOURNAL AND PROCEEDINGS OF THE ROYAL SOCIETY OF NEW SOUTH WALES FOR 1915, Vol. xlix., Part III., Part II. (pp. 257-525), containing papers read in November and December, with 36 plates, 1915. Sydney: George Robertson. Demi. 8vo.

COLLECTED PAPERS ON ANALYTICAL PSYCHOLOGY, by C. G. Jung, M.D., LL.D., authorized translation edited by Dr. Constance E. Long, 1916. London: Baillière, Tindall and Cox, demi 8vo., pp. 392. Price 12s. 6d.

CEREBRO-SPINAL FEVER, by Michael Foster, M.A., M.D., and J. F. Gaskell, M.A., M.D., 1916, Cambridge: at the University Press. Crown Quarto, pp. 222.

MODERN MEDICINE AND SOME MODERN REMEDIES—PRACTICAL NOTES FOR THE GENERAL PRACTITIONER, by Thomas Bodley

Scott, with a preface by Sir Lauder Brunton, Bart., F.R.S., 1916. London: H. K. Lewis and Co., Ltd. Crown 8vo., pp. 159. Price, 4s. 6d.

ON MODERN METHODS OF TREATING FRACTURES, by Ernest W. Hey Groves, M.S., M.D., B.Sc., F.R.C.S., 1916. Bristol: John Wright and Sons, Ltd. Demi 8vo., pp. 286. Price, 7s. 6d.

STUDIES IN SURGICAL PATHOLOGICAL PSYCHOLOGY FROM THE LABORATORY OF SURGICAL RESEARCH, 1915. New York University. Vol. I., demi. 8vo., pp. 631.

THE SEX COMPLEX: A STUDY OF THE RELATIONSHIP OF THE INTERNAL SECRETIONS TO THE FEMALE CHARACTERISTICS AND FUNCTIONS IN HEALTH AND DISEASE, by W. Blair Bell, B.S., M.D., 1916. London: Baillière, Tindall and Cox. Demi 8vo., pp. 233, with illustrations. Price, 12s. 6d.

A NEW TREATMENT OF GONORRHŒA, by Charles Russ, M.B., M.R.C.S., L.R.C.P., 1916. London: H. K. Lewis and Co., Ltd. Demi. 8vo., pp. 38. Price, 3s.

DISEASES OF THE NOSE AND THROAT, COMPRISING AFFECTIONS OF THE TRACHEA AND OESOPHAGUS, by Sir St. Clair Thomson, M.D., F.R.C.P., F.R.C.S. Second edition, with 22 plates in the text. 1916. London: Cassell and Co., Ltd. Roy. 8vo., pp. 858.

THE PRACTICAL MEDICINE SERIES, VOL. I., GENERAL MEDICINE, under the direct editorial charge of Charles L. Mix, A.M., M.D., edited by Frank Billings, M.S., M.D., series 1916. Chicago: The Year Book Publishers. Demi 8vo., pp. 384. Price, 7s.

Medical Appointments.

It has been announced that Dr. D. G. Robertson, who has been acting as Chief Health Officer for a time in Tasmania, is about to resume duties as a quarantine officer. He will be stationed in Western Australia.

Dr. H. H. Field Martell has been appointed Officer of Health for the Bacchus Marsh Shire and the North and South Ridings of the Melton Shire, Victoria, in place of Dr. T. B. Ryan, resigned.

Dr. A. L. B. Best has been appointed Officer of Health for the Western Riding of the Maffra Shire, Victoria, in place of Dr. E. B. Heffernan, resigned.

Dr. E. H. Lindsay has been appointed Officer of Health for the Walpeup Shire, Victoria, in place of Dr. R. C. Hart, resigned.

Dr. H. W. Bryant has been appointed a Medical Referee under the provisions of Section 26 of the Workers' Compensation Act, 1915, Victoria.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxi.

Texas District Hospital, Queensland, Medical Officer.
Brisbane Hospital, Resident Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute. Ladley Hospital, Medical Officer.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—New Appointments as Medical Officer, Ophthalmic Surgeon, Ear, Nose and Throat Surgeon, Physician. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
NEW ZEALAND: WELLINGTON DIVISION. Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

June 7.—Vic. Branch, B.M.A., Branch.
June 9.—S. Aust. Branch, B.M.A., Council.
June 9.—N.S.W. Branch, B.M.A., Clinical.
June 13.—Tas. Branch, B.M.A., General.
June 13.—N.S.W. Branch, B.M.A., Ethics Committee.
June 14.—South Sydney Med. Assoc (N.S.W.).
June 15.—Vic. Branch, B.M.A., Council.
June 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
June 21.—W. Aust. Branch, B.M.A., General.
June 23.—Q. Branch, B.M.A., Council.
June 27.—N.S.W. Branch, B.M.A., Medical Politics Committee, Organization and Science Committee.
June 28.—Vic. Branch, B.M.A., Council.
June 29.—S. Aust. Branch, B.M.A., Annual General Meeting.
June 30.—N.S.W. Branch, B.M.A., Ordinary.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.